State of Illinois
Illinois Department on Aging

Registration for Congregate Meals

Name of Site: _____ ☐ **New Client** ☐ **Renewal**

This form must be completed by the appropriate Congregate nutrition provider.

Older Adult Demographic Information					
Date:	Name:		DOB:		
Address:	City:		State:	Zip:	
Email:	Phone:		Cell Phone:		
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino			Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Legally Separated ☐ Domestic Partner	Gender: ☐ M ☐ F Other:	
Race: ☐ White ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Asian or Asian American ☐ Native Hawaiian or Pacific Islander					
Limited English Speaking: ☐ Yes ☐ No If yes, specify language:_____	Monthly Income:_____ Below Poverty: ☐ Yes ☐ No		☐ Lives Alone ☐ Lives with Others # of Individuals in Household: _____		

Major Health Problems (check all that apply)

☐ Ambulation ☐ Hearing ☐ Vision ☐ Other:_____

Nutrition Risk Screen (select Yes or No)

	Y	N		Y	N
I have an illness or condition that made me change the kind and/or amount of food I eat.	☐	☐	I don't always have enough money to buy the food I need.	☐	☐
I eat fewer than 2 meals per day.	☐	☐	I eat alone most of the time.	☐	☐
I eat few fruits and vegetables, or milk products.	☐	☐	I take 3 or more different prescribed or over-the-counter drugs a day.	☐	☐
I have 3 or more drinks of beer, liquor, or wine almost every day.	☐	☐	Without wanting to, I have lost or gained 10 pounds in the last 6 months.	☐	☐
I have tooth or mouth problems that make it hard for me to eat.	☐	☐	I am not always physically able to shop, cook, and/or feed myself.	☐	☐
Totals	0	0	**Totals**	0	0

Six or more points = High Nutritional Risk **Combined Column Totals:** 0_____**/21 Possible Points**

☐ Nutritional Risk was explained to client.
☐ Client is considered at High Nutritional Risk. A recommendation was made to follow-up with a healthcare provider.

Additional Nutrition Information

Does Older Adult have difficulty chewing/poor dental health? ☐ Yes ☐ No	**Special Diet Needs:** ☐ General ☐ Diabetic ☐ Other:
Client food source for the weekends:	**Dietary Restrictions:**

Food Allergies ☐ Yes ☐ No If yes, specify:

NOTE: It is the client's responsibility to review the weekly menu and bring any allergy concerns to the attention of the nutrition provider. When feasible, the provider will supply a special meal to meet the dietary needs of the client.
☐ The client was informed of the possibility that foods may contain or come into contact with food allergens.

Other Contact Information

Emergency Contact Name #1:	Daytime/Cell Phone:
Emergency Contact Name #2:	Daytime/Cell Phone:

Authorization of Release of Information

I give permission to the provider and/or the Area Agency on Aging Staff to discuss my needs.

Client Signature:	**Date:**

Staff Person Initials:_____